

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COMPREHENSIVE HOME BASED SERVICES

Effective: 1/1/2015
Revised 12/2/2014

I. Services Description

Provision of comprehensive and intensive home based services for families involved with DCS/Juvenile Probation to address the short and long term behavioral health care needs. This service shall be for the entire family. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need and congruent with the DCS case plan. These in-home services must be evidence based models or promising practices, family centered, and culturally competent. Fidelity to the chosen evidence based model should be documented.

Examples of therapeutic interventions that are evidence-based models such as:

- Trauma-Focused Cognitive Behavioral Therapy,
- Family Centered Treatment*
- Alternative for Families Cognitive Behavioral Therapy,
- Cognitive Behavioral Therapy,
- Motivational Interviewing,
- Child Parent Psychotherapy,
- Parent Child Interactive Therapy,
- ABA, OR
- Other DCS approved treatment models

*For those implementing Family Centered Treatment, please reference the Comprehensive Service Standard - FCT addendum located at: <http://www.in.gov/dcs/3395.htm>.

Additional evidence-based programs are outlined at:

- The California Evidence- Based Clearinghouse at www.cebc4cw.org or
- The National Registry for Evidence Based Programs-SAMHSA (Substance Abuse and Mental Health Services Administration) at www.nrepp.samhsa.gov or
- The Office of Juvenile Justice and Delinquency Prevention at <http://ojjdp.ncjrs.gov>

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The service shall be all inclusive (as defined below) and must aim at improving long term outcomes for children and their families by providing services that are effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being. Additionally, the Home-Based Service must monitor and address any safety concerns for the child(ren). The intervention must be strength-based and family driven with the family participating in identifying the focus of services.

Additionally, the provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365 days a year.

II. Inclusive Service Model

The service shall be all inclusive to meet the needs of the family. There should not be a need for DCS to contract/refer the child(ren) or family for additional services as the service provided shall be all inclusive to meet the needs of the family. The service includes but is not limited to assessment of service need, home based casework services, homemaker services, visitation supervision, parent engagement services, parent education, and transportation assistance. Home based therapeutic services may be included, but it is not required. Examples of services that may be outside of the services provided under this Service Standard include: Translation Services, Diagnostic and Evaluation Services, Residential Substance Use Treatment services, Detoxification Services and other medical services, Substance Use Outpatient Treatment. Given the dynamic range of evidence-based models and promising/research-informed practices that may fall under this service standard, there may be some variation in what is considered outside the "all inclusive" services. To avoid confusion regarding services payable in addition to the Comprehensive Home Based Services per diem, provider must actively communicate with the assigned DCS family case manager to determine which services are appropriate for the family and are consistent with model or practice in place.

If the requested/required supervised visitation needs exceed what is thought to be reasonable as part of the comprehensive service, the provider must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable units.

III Quality Service Reviews

In order to ensure providers are offering services in accordance with the DCS practice model, providers should be trained in the Quality Service Review process and participate in the regional Quality Service Reviews. This information will be valuable to your agency in understanding the Practice Model and quality standards in which the system is measured. Understanding quality expectations will assist your agency in planning and implementing services.

The Comprehensive Home-based Service Standard requires only that one person from each agency participate in the QSR as a shadow for each region they serve. If your agency is interested in completing the entire training process that is permitted, but is not required.

The agency will need to select one individual from within the agency to participate in the QSR. That person will need to attend a 2 day training on the QSR Protocol and process. Following training, providers will be required to attend QSR in the regions in which they provide services through the comprehensive contract. Providers will participate in the QSR as a shadow reviewer. Each QSR is scheduled for two consecutive days, beginning at 8am and ending no later than 8pm. An agency will need to select a minimum of one representative to participate in the QSR in each region they provide comprehensive services in. This could be the same person for all regions or a different person for each region. Each person participating in the QSR must first complete the two day training.

Providers will not be penalized if the available reviewer positions are full. The provider should simply wait for the next QSR round for the Region. The agency needs to shadow in each region that they provide services. The Service Standard requires only that the individual shadow in each region that service is provided. The cost of participation in the QSR is included in the comprehensive service rate. Therefore, individuals who participate in the QSR should inquire about reimbursement for travel and lodging from their provider agency.

IV. Target Population

All clients served must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Note: The specific service model chosen to be used under this Service Standard may require a more focused population. However, all clients served under this Service Standard must fit within the above eligibility categories.

V. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular timely communication with referring worker.

Objectives:

- 1) Staff is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
- 2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
- 3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

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Objectives:

1) Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face-to-face intake and a written report signed by the Direct Worker and the client is submitted to the current FCM/Probation Officer.

Client Outcome Measures:

- 1) ___% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) ___% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) ___% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 4) ___% of the children/youth involved with an open JD/JS case will have no occurrences of reoffending throughout the service provision period.
- 5) ___% of those individuals/families with a successful case closure will not have a further incident of abuse or neglect at 12 months post discharge.
- 6) ___% of those children/youth with a successful case closure will not have any occurrences of reoffending at 12 months post discharge.

Goal #3 DCS/Probation and clients will report satisfaction with services.

Outcome Measures:

- 1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

VI. Minimum Qualifications

The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete the service as required by state law. At a minimum, the following apply.

Direct Worker/Case Manager:

Bachelor’s Degree in social work, psychology, sociology, or a directly related field. Other Bachelor’s degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver’s license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child’s culture, entitlement, gratification delaying, flexible parental roles and humor

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Supervisor:

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

Direct Worker/Therapist:

Master's degree in social work, psychology, marriage and family therapy, or related human service field, and 2 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor.

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

Supervisor:

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Social Worker, Marriage and Family Direct Worker, or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

Additional Staff:

Support staff may be used to supplement the professional staff when approved as part of the model or a supplement to the model. These staff must be trained in the basic principles of the chosen model and their practice must be coordinated and directed by the direct professional staff.

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Note: When treatment/service models chosen and/or Indiana licensure/certification bodies require a higher level of staffing qualifications than above, those qualification requirements shall be followed. It is the responsibility of the provider to maintain staff with the skills necessary to effect change in the families that will be referred. This responsibility includes the supervision and training of the staff. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body and the Evidence Based Practice Model or Promising Practice Model that is being provided. Supervision may include individual, group, and direct observation modalities and can utilize teleconference technologies.

Staff must possess a valid driver’s license and must comply with the state policy concerning minimum car insurance coverage.

VII. Reporting

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service.

DCS will require an electronic reporting system which will include documenting time and services provided to families. This information must be entered into KidTraks within 48 hours of providing the service to the family. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

VIII. Billable Unit

Per Diem rate: The per diem will start the day of the first face to face contact after recommendation for acceptance into this program is approved by DCS. The per diem rate will be all inclusive of the services outlined in Section III above.

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Weekly Hours:	8 Hours Direct Time	8 Hours Direct Time	8 Hours Direct Time	5 Hours Direct Time	5 Hours Direct Time
Primary Worker:	Therapist	Bachelors	Bachelors	Bachelors	Bachelors
Minimum Face to face Therapy Hours per week	3 over a minimum of 2 face to face contacts	1	0	1	0

Minimum Face to Face Case Management hours per week	0	2 over a minimum of 2 face to face contacts	3 over a minimum of 2 face to face contacts	1	2 over a minimum of 2 face to face contacts
Case Load for primary staff:	5	5	5	8	8
Team structure	<ul style="list-style-type: none"> Therapist - primary Support staff 	<ul style="list-style-type: none"> Case Manager – primary Therapist Support staff - optional 	<ul style="list-style-type: none"> Case Manager- primary Support Staff- optional 	<ul style="list-style-type: none"> Case Manager- primary Therapist 	<ul style="list-style-type: none"> Case Manager- primary Support Staff
Direct vs. Indirect hours Note: all tiers are required to meet the 80%Direct vs 20% Indirect hours of service requirement over the intervention.	180 hours/ 6 months 80% Direct= 144 hours 20% indirect= 36 hours *Calculation allows for a maximum of 1 hour of direct support per week, remaining time is a calculated total of the primary workers time across the intervention.	180 hours/ 6 months 80% Direct=144 20% indirect =36 *Calculation allows for a maximum of 1 hour of direct support per week remaining time is a calculated total of the primary workers time across the intervention.	180 hours/ 6 months 80% Direct =144 20% Indirect=36 *Calculation allows for a maximum of 2 hours of direct support per week, remaining time is a calculated total of the primary workers time across the intervention.	120 hours / 6 month 80% Direct = 96 20% Indirect=24	120 hours / 6 month 80% Direct = 96 20% Indirect=24 * Calculation allows for a maximum of 1 hour of direct support per week, remaining time is a calculated total of the primary workers time across the intervention

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Direct service (minimum 80%) includes:

- Family specific face to face contact with the identified family during which services are defined in the applicable service standard are performed. Members of the client family are to be defined in consultation with the family and approved by the DCS office. This may include persons not legally defined as part of the family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by DCS for the purpose of goal driven communication regarding the services being provided to the family
- Includes in-vehicle (or in transport) time with client provided it is identified as goal directed, face-to-face, and approved/specified as part of the family's intervention plan
- Includes crisis intervention and other goal-directed interventions via telephone with the identified family
- Includes time spent completing any DCS approved standardized tool to assess family functioning
- Supervised visitation is included in the minimum direct service hours if it includes a therapeutic component and/or modeling and coaching the parent to improve parenting skills

Indirect service (maximum 20%) includes:

- Routine report writing
- Travel time
- Court attendance when requested
- Crisis intervention and other goal directed interventions via telephone with the identified client/family
- Comprehensive case management including stakeholder/referral/collateral contact. Contact with referring/community stakeholders or collaterals for the purpose of case coordination, updating, planning, case staffing, child and family team meetings, court, or other information shared for the advancement and benefit of the family to complete the identified service plan goals
- Clinical service/treatment planning/case assessment. Examples of allowable components include development of clinical service components necessary for provision of services, service treatment plan development, clinical case assessment and planning, necessary case coordination documentation as required by DCS, other specific assessment tools as defined by DCS, review of video session if required by the EBP model, discharge planning/documentation
- Supervision – time allotted for supervision is dedicated to case staffing/assessment/planning specific to the client/family

Translation services may be added as needed as an additional billable unit.

If the requested/required supervised visitation needs exceed what is thought to be reasonable as part of the comprehensive service, the provider must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable units.

DCS has determined that the services that are provided under this service standard are not appropriate to be billed to Medicaid.

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IX. Case Record Documentation

Case record documentation for service eligibility must include:

- A completed, signed, and dated DCS/ Probation referral form authorizing services
- Documentation of regular contact with the referred families/children
- All KidTraks entries will be made with 48 hours of contact or event
- Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

If a child is the only child participating in services and there are no other siblings, and that child is in residential placement, the child must be transitioning to a less restrictive placement within the next 30 days for the referral to be made.

Provider to contact Family Case Manager after missed appointments. After three unsuccessful face to face contacts, the provider must notify the Family Case Manager and billing must be suspended until successful face to face contact is made. Family Case Manager should be contacted to evaluate the need for early termination of the referral.

Providers must initiate a re-authorization for services to continue beyond the approved period. All comprehensive referrals are created for 1 year and include 185 units. Once the 185 units have run out, requests for continued services must be processed in central office and require approval.

A referral from DCS does not substitute for any authorizations required by the Medicaid program.

- Referral must be accepted within the KidTraks vendor portal within 72 hours
- Provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity
- Providers will see the family within 48 hours of referral

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XI Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, and planning and intervening to partner with families and the community to achieve better outcomes for children.

XII. Core Competency - Trauma Informed Care

Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIII. Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>

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Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XIV. Child Safety

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.